BQC - 90 - 075

Date: September 13, 1990

To: All Wisconsin Long Term Care Facilities, ICFs/MR, and Hospitals

From: Larry Tainter, Director
Bureau of Quality Assurance

Subject: New Federal Requirements for Comprehensive Resident Assessment in Long Term Care Facilities, and Corresponding Changes in the State's Patient Plan of Care (PPOC) Procedures for All Nursing Homes

The federal Health Care Financing Administration's new regulations for long term care facilities participating in the Medicare and Medical Assistance programs go into effect on October 1, 1990. These regulations are located in 42 CFR Part 483, Subpart B, and include new requirements relating to resident assessments in Section 483.20. While these rules do not apply to intermediate care facilities for the mentally retarded (ICFs/MR), which are governed by a separate set of regulations in 42 CFR Part 483 Subpart D, or to hospitals, we have addressed this letter also to ICFs/MR and hospitals so that you are aware of the changes occuring in the long term care facilities. (The term "long term care facility" is used by HCFA to describe skilled nursing facilities (SNFs) that participate in the Medicare program and nursing facilities (NFs) that are Medicaid certified.)

Under the new long term care regulations, a comprehensive, accurate, standardized, reproducible assessment of each resident;s needs is to be done for all new admissions beginning on October 1, 1990, and for all current residents of the facility by October 1, 1991. It is to be based on a uniform data set and prepared on an instrument specified by the state. Wisconsin has decided to mandate the resident assessment instrument supplied by the Health Care Financing Administration, often referred to as the Minimum Data Set ("MDS"). This resident assessment instrument is actually a standardized system with three component parts:

1. A Minimum Data Set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident;

2. Resident Assessment Protocols (RAPs) which are structured frameworks for organizing the MDS elements to develop care plans. These include "triggers", which aggregate and cross reference the MDS elements to the RAPs;

3. Utilization guidelines to describe when and how to use the resident assessment instrument.

Facilities should refer to the detailed guidelines, at 42 CFR 483.20, for the general requirements for the resident assessment process. Some items such as information on vital signs, diagnostic tests and drug therapy are required in the assessment process but are not included directly in the Minimum Data Set (MDS) form.

Wisconsin is specifying the instrument to be used for the comprehensive assessments based on direction from HCFA and on the authority of the nursing home licensing rule, HSS 132. A rule revision is underway that describes the forms on which assessments are to be completed. We expect to have the rule revision promulgated effective 12/1/90. Although for the months of October and November of 1990 the use of this particular instrument is not required by state rule for the comprehensive resident assessments, we encourage all facilities to begin using it in October. Beginning 12/1/90 the use of this resident assessment instrument, with its three component parts, is mandatory for conducting assessments in long term care facilities. Computerized versions of the MDS forms will be acceptable as long as they contain the same information and follow the same sequence as the HCFA MDS forms.

Copies of the forms and ordering information will be supplied very shortly. We have just received word that HCFA has made some modifications to the MDS form dated 4/1/90 that has been widely circulated in the industry. As soon as we can print the updated version, which has a date of 8/20/90, we will send out samples of the MDS forms, the resident assessment protocols, and utilization guidelines along with ordering information.

HCFA has advised the states that the Inspection of Care (IoC) reviews can be discontinued once an instrument has been mandated on a statewide basis. Therefore, we are planning to eliminate the IoC reviews in long term care facilities effective 10/1/90, since we will have specified an approved assessment instrument during the October-December quarter. The OBRA law eliminated IoCs for nursing facilities only, so the IoC will continue to be performed in ICFs/MR and psychiatric hospitals.

In place of the IoC reviews, BQC will conduct a care level review of all residents in long term care facilities who are Medical Assistance recipients. Generally, this will be scheduled at the end of the facility's annual survey, and conducted by the same nurses who are involved in the survey. This care level review will be done by observation of residents and chart review.

In recognition of the changes being made in regard to resident assessments and the Inspection of Care, and the fact that there will be a standard form used for collecting this data, the Bureau of Quality Compliance will also modify procedures for setting care levels for Medical Assistance in long term care facilities beginning 10/1/90. The PPOC form will be replaced by a new on-epage form titled "Request for Title XIX Care Level Determination". Instead of submitting a PPOC to request a care level, long term care facilities will submit this form with the MDS form as an attachment. (Please note that the PPOC form will continue to be used for ICFs/MR facilities and for other programs, such as the Community Options Program. The Division of Health will continue to supply this form.)

In addition to the changes described above which apply to long term care facilities only, there is also a change in PPOC processing requirements which applies to <u>all</u> nursing homes, including ICFs/MR. Effective 10/1/90 for all care level determinations, whether they are done for long term care facilities or ICFs/MR, and whether they are done with a PPOC form or with the new Request for Title XIX Care Level Determination, we encourage you to submit the requests in a <u>timely</u> fashion. The 20-day deadline that was announced in BQC memo 89-052 is no longer in effect. If they are submitted within 30 days of the admission or date the facility is notified of MA eligibility, BQC will commit to a 30-day turnaround to get the authorization on the MMIS data base at EDS-Federal. The outside limit for submitting requests to Title XIX authorization under Medical Assistance rules in one year from the date of service. BQC will review our files to identify cases which were denied coverage because they were not submitted within 20 days, and authorize payment for dates of service that were within one year of the request date.

We will send samples of the resident assessment instrument and the new Title XIX care level determination form as soon as they are all available. In the meantime, if you have questions about the resident assessment requirements or the changes in determining Medical Assistance Coverage for nursing home care, please contact the Field Operation Manager assigned to your facility.

LT/SW/jh 2908

cc: Bd. on Aging & Long Term Care
Wisconsin Association of Homes & Services for the Aging
Wisconsin Association of Nursing Homes
Wisconsin Counties Association
Wis. Medical Records Assoc. Consultants Committee
Service Employees International Union
Wisconsin Coalition for Advocacy
Comm. on Aging, Extended Care Facilities & Home Health Care
Wisconsin Association of Medical Directors
Wisconsin Hospital Assocation
George F. MacKenzie
Director, Bureau of Health Care Financing
Admin., Division of Care & Treatment Facilities
Jerry Sandlin, HCFA, Chicago